Department of Corrections
WASHINGTON STATE

PATIENT I.D. DATA:
(name, DOC #, birthdate)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____, hereby authorize the use or disclosure of my health information as described below. The following individual or organization is authorized to make the disclosure:

(INFO FROM) NAME: _____

ADDRESS: _____

_____

_____

The type and date(s) of information to be used or disclosed are:

_____

_____

_____

_____

Password (required for verbal disclosure)**:** _____

☐ Substance abuse/CD treatment records are also being requested (requires DOC form 14-172, Substance Abuse Recovery Unit Compound Release of Confidential Information, or equivalent)

Purpose for disclosure: _____

I understand that the information in my health record may include information relating to sexually transmitted infections, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

(INFO TO) NAME: _____

ADDRESS: _____

_____

_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department of the entity listed as (FROM) above. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ (if left blank, authorization will expire upon release from DOC custody or six (6) months from date of signature, whichever is later).

I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524 and RCW 70.02. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal or state confidentiality rules. If I have questions about disclosure of my health information, I may contact the RHIA/RHIT/designee of the facility: _____.

_____	_____
Signature of Patient (Do not sign if form is not complete)	Date (Patient to complete)

_____	_____	_____
Last four digits of SSN	Date of Birth	DOC Number

Requesting provider: _____ Date mailed/faxed: _____

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.